MYgroup
McLAUGHLIN YOUNG

Authorization for Release of Client Records

Client Name:_____ Date of Birth: _____

I request and authorize McLaughlin Young Group (MYG) to:

☐ Release the following information to: ☐ Receive the following information from:

Name of Facility/Person: _____

Address:_____ Phone: _____

Release is for the Purpose of:

- ☐ Continued care by the other provider
- ☐ Attorney
- ☐ Disability
- ☐ Supervisor Referral
- ☐ Personal Review
- ☐ Other (specify): _____

Information to be Disclosed If Requested:

- ☐ Service dates
- ☐ Session constellation
- ☐ Session participants
- ☐ Clinical assessments
- ☐ Summary oftreatment
- ☐ Other (specify): _____

I understand that the information I am authorizing to be released may include mental health information and any therapy constellation (individual, couple, family, group) in which I have participated.

I further understand that this Authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form (45 C.F.R. 164.508 (c)(2)).

I further understand that I may revoke this Authorization at any time by notifying McLaughlin Young Group (or the releasing facility) in writing by certified mail, return receipt requested to the CEO of MYG, except to the extent that action has been taken in reliance on it. Any such revocation shall not be effective until the next business day following receipt of the revocation notice by MYG. Unless earlier revoked, this Authorization expires automatically 1 year from the day signed or 1 year after the last MYG visit (45 C.F.R. 164.508 (c)(2)).

I further understand that if I refuse to authorize the release of information in a situation where the information is needed by the Employer for legal or other reasons of business necessity, it may limit MYG's ability to continue to provide services in which case MYG may make a referral to another health care provider.

Any person or other entity who receives information pursuant to this authorization should not re-disclose the information to anyone else.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

RELEASE FROM LIABILITY I release and agree to hold harmless MYG (or other releasing facility) and its agents, representatives, and employees from any and all liability associated with the release of confidential client information in accord with this Authorization.

I understand that MYG (or the releasing facility) cannot be responsible for use or re-disclosure of information to third parties (45 C.F.R. 164.508 (c)(2)).

TO THE RECEIVING PARTY OF THIS INFORMATION:
This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the client is prohibited. These records may be protected by federal regulation (42 C.F.R. Part 2).

I certify this form was fully explained to me, I have read it or have had it read to me*, and I understand its contents.

_____ _____ _____
Print Client Name/Legally Authorized Person Signature Date

_____ _____ _____
Print Witness/Translator* Name Signature Date